TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GLENN J BRICKEN PSYD

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-17-0508-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
October 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TAC 134 states that the insurance carrier shall not deny reimbursement based on medical necessity for health care that was preauthorized. We respectfully request medical fee dispute resolution."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the Medical Dispute, the bills were reviewed. Per Rule 133.307, MDR is to be filed no later than one year from the date of service. The date of service in dispute is 7/10/14, therefore the MDR has not been filed timely."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 10, 2014	90791	$500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W9 – Unnecessary treatment with peer review
   - 18 – Duplicate claim/service

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Did the Requestor waive the right to medical fee dispute resolution?

Findings

1. The requestor seeks reimbursement for CPT Code 90791 rendered on July 10, 2014 in the amount of $500.00. The insurance carrier denied/reduced the disputed charge with reason(s) code "W9 – Unnecessary treatment with peer review." The Division finds that the requestor submitted a copy of a preauthorization letter to support that the disputed service was preauthorized. As a result, the denial of medical necessity is not supported. The Division will review the disputed charge to determine if the disputed date of service was submitted within the one year filing deadline.

2. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is July 10, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 25, 2016. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services does not involve issues identified in §133.307(c) (1) (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 10, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.